23530 Kingsland Blvd | Suite 100
Katy | TX 77494
Tel: 832-844-1470
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REQUEST FOR TRANSFER OF HEALTH INFORMATION / MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA), this practice may not disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization*. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I HEREBY REQUEST THE TRANSFER OF RECORDS FOR:

Patient's Full Name: ____
Date of Birth: _____/_____/_____
Address: ____
City/State/Zip Code: ____
Daytime Phone Number: ( ) _____ --- ________ ☐ Cell # ☐ Work # ☐ Home #

TYPE OF RECORD REQUESTED: Entire copy of the entire medical record, as allowed by law.

TO BE TRANSFERRED FROM:

Practice Name: ____
Address: ____
City/State/Zip Code: ____
Phone Number: ____

TO BE TRANSFERRED TO: **Springtime Pediatrics,** at the address above

Requestor's Full Name: ____

Requestor's Signature: ____

Date of Request: _____ / _____ / _____

By my signature I certify that I am the parent or legal guardian of the parent named here. If there is more than one Child in the family, please complete a separate form for each child.

* The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501